EXHIBIT "K"

MAIL RETURN ONLY PO BOX 8486 · CORAL SPRINGS FL 33075-8486

800-984-9115

en Español 800-398-3975

August 16, 2018



HRRG ▲ 000007

SAMPLE PATIENT APT#453 2801 NW 60TH AVE APT 453 SUNRISE FL 33313-2283

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Re: 23361550 Final Notice hrrgcollections.com PIN# 1.23361550.504

Dear Sample Patient:

Some time ago, the health care provider(s) listed below, hired Healthcare Revenue Recovery Group, LLC (HRRG) to collect the balance shown below. Despite our collection efforts, all or at least part of your balance remains outstanding. As such, we are writing to advise you that we are evaluating this account for potential sale to a debt buyer; for placement with another collection agency; or for transfer to ARS Account Resolution Services (ARS), a division of HRRG.

HRRG has not reported this account to any credit bureaus. However, you should be aware that if the account is sold or transferred, either the new agency; the new owner; or ARS may choose to report this account as a delinquent debt to the major credit bureaus. (NOTICE: SEE REVERSE SIDE FOR IMPORTANT INFORMATION).

We want to work with you to resolve this matter. Please call us toll free at 800-984-9115 to discuss payment on this account.

Best regards from,

Healthcare Revenue Recovery Group, LLC

(NOTICE: SEE REVERSE SIDE FOR APPLICABLE DISCLOSURES AND PAYMENT INFORMATION.)

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Reference #: 23361550

Total Balance: \$1394.80

Amount Enclosed \$

Creditor EASTSIDE HOSPITALIST INPHYNET S BROWARD Account #
invoicetst-mrntest
invoicetst-mrntest

Regarding SAMPLE PATIENT SAMPLE PATIENT

592.82 07/22/15 801.98 07/22/15

ServDate

Amt Owed

PO BOX 5406 CINCINNATI OH 45273-7942 Idadahari Hadahari Albahari

ARS 15

| Case 1:17-cv-00928-CPO-EAP Document 125-14 File | au u7705722 - Pau | ie 3 di 3 PadelD | . TZ90 |
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This is an attempt to collect a debt from a debt collection agency. Any information obtained will be used for that purpose.

Credit Card payments will appear on your next credit card statement as "HRRG".

For your convenience you may pay by MasterCard,VISA, American Express or Discover. Check the appropriate box, print the cardholder's name as it appears on the card, the card number, the expiration date, sign and return this portion of your statement.

| INSURANCE INFORMATION Insurance Company: | |
|--|---|
| Claims Address: City, State, Zip: | |
| Policy Number: | |
| Subscriber's Name: | |
| Medicare Number: | NAME AS IT APPEARS ON CARD - PLEASE PRINT |
| • | Apt./Unit#: |
| City: | |
| | ARS 16 |